Testimony before the Joint Oversight Committee on Maryland Health Benefit Exchange
February 10, 2014

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Summary

Thank you for the opportunity to testify today on the status and future of the Maryland Health Benefit Exchange. In our testimony, we will provide updated data and information on enrollment, consumer assistance, spending, IT contracts, a variety of IT issues, and next steps.

We would like to begin with two important comments. First, we have seen considerable improvement in the the user experience on the website after a series of fixes in early December. For consumers who do have difficulty, there are many trained staff, including navigators and call center employees, to help. Thousands of Marylanders are accessing quality and affordable health coverage, and we encourage all Marylanders who need coverage to visit Maryland Health Connection dot gov, or to call 1-855-642-8572 to enroll through the end of the open enrollment period on March 31.

Second, the decision by the Governor and Lt. Governor to use our current IT platform through the end of the open enrollment period on March 31, does not mean that we're satisfied with the way that the system is functioning. They decided to use our current IT platform through the end of the open enrollment period because that was the best path to maximizing the number of enrollments by March 31. Nevertheless, there remain serious IT defects with the system. These defects can cause frustration for some consumers and are requiring substantial manual work in certain cases to successfully complete enrollments.

As a result, we are actively investigating alternative options for the second open enrollment period, beginning in November 2014. These alternative options include adopting technology developed for other states, partnering with the federal exchange for back-end functions, and implementing major fixes to our current technology.

We will keep the Joint Oversight Committee and the General Assembly up to date on our plans.

Update on Enrollment

Through February 1, 2014, there have been 932,764 unique visitors to the Maryland Health Connection website.

151,593 Marylanders have created identity-verified accounts.

So far, 29,059 Marylanders have chosen to enroll in private health plans through Maryland Health Connection, and 140,416 have obtained Medicaid coverage starting January 1.

Qualified health plans. Through February 1, 29,059 Marylanders have chosen to enroll in private health plans through Maryland Health Connection.

Of these, 16,162 (55.6%) are female, and 12,897 (44.4%) are male.

The age distribution is the following:

Age	Number	Percentage
Younger than 18	1,245	4.3%
18-25	2,651	9.1%
26-34	5,223	18.0%
35-44	5,083	17.5%
45-54	6,803	23.4%
55-64	7,705	26.5%
65 or older	349	1.2%

The plan characteristics are the following:

Metal Level	Number	Percentage
Catastrophic	150	0.5%
Bronze	7,625	26.2%
Silver	13,620	46.9%
Gold	4,906	16.9%
Platinum	2,758	9.5%

Final data on how many of the individuals choosing qualified health plans have effectuated their coverage by paying the premium is not available, because the final date of payment for January 1 coverage has not passed.

We are aware that there were some individuals who would have enrolled by January 1, but were unable to do so -- through no fault of their own -- because of technological problems with the site. In addition to improving the site and boosting the number of call center personnel on hand to assist people, we have taken two other actions to address this problem:

- First, we worked with insurers to offer retroactive coverage back to January 1.
- Second, with the help of the General Assembly, we passed an MHIP bridge. Both of these steps were designed to do everything we could to make sure no one slipped through the cracks.

Retroactive option. After outreach and inbound calls, and after removing duplicate entries, 1,333 unique households registered to explore the possibility of retroactive coverage to January 1. Follow-up phone calls found that 562 families were eligible for Medicaid, 263 declined to enroll, 74 chose to enroll effective March 1, 133 households were not reachable despite multiple phone attempts, and four were referred directly to a carrier for unsubsidized coverage. We identified 297 households with 444 individuals that chose to enroll in coverage through the exchange retroactive to January 1.

MHIP Bridge. As of February 7, no Marylanders had signed up for the MHIP bridge option. Information on this option is available online at http://www.marylandhealthinsuranceplan.net

Medicaid. As of February 1, 140,416 Marylanders have enrolled in Medicaid with coverage effective January 1. Of these, 95,824 signed up through the Primary Adult Care program.

Consumer Assistance

Marylanders have accessed consumer assistance through four principal mechanisms.

Consumer Assistance	Number	Type of Assistance
Certified Individual Navigators	183	Provide full scope of in-person assistance with eligibility determination and enrollment in Medicaid managed care organizations and qualified health plans
Assisters	218	Provide outreach and education services and assistance with eligibility applications; may not provide assistance with enrollment

Producers	1,877 authorized, including 52 captive producers	Provide assistance with eligibility determinations and enrollment in qualified health plans; may not assist with Medicaid enrollment
Call Center Customer Service Representatives	363 + 53 (supervisors, quality control, and other support staff) = 416	Provide full scope of assistance by phone with eligibility determination and enrollment in Medicaid managed care organizations and qualified health plans

The call center has handled more than 265,000 calls since October 1. After a substantial spike in calls in December, the Maryland Health Benefit Exchange board tripled the number of call center workers from 120 to 363. The call center is anticipated to have its full staff in place and certified by the end of February.

Some key statistics for the call center include the following:

Month	Total Received	Average Daily	Speed to answer	Talk Time
October	44,325	1,430	0:22	8:12
November	40,939	1,412	3:03	12:11
December	83,820	2,787	37:54	17:48
January	94,401	3,045	28:30	n/a

An important functionality for consumers is the ability to leave a message and receive a call back. The return call feature was disengaged in mid-December, because significantly increased call volumes meant that call center representatives were not able to return calls within a reasonable time frame. The call center intends to re-engage this feature within the next two weeks once the newly hired additional staff has been trained.

Application Counselor Program. The Application Counselor Sponsoring Entity designations will be announced today. 33 have been approved, and they will have an estimated more than 500 individual Certified Application Counselors. Counselors will be able to provide application assistance with eligibility determinations and enrollment in qualified health plans, but may not assist with enrollment in managed care organizations. The Maryland Health Benefit Exchange plans to begin the training and credentialing of the individual counselors within the next couple of weeks.

Insurance brokers. 2148 of the enrollments in qualified health plans to date have come through brokers. We do not have specific data on navigators or other channels of consumer assistance.

Spending

The Maryland Health Benefit Exchange has responded to the January 23 letter of Chairman Hammen, providing detailed fiscal information on FY 12 through the budget proposal in FY 15. This information covers all expenses from the Maryland Health Benefit Exchange, including IT, outreach, salaries, etc.

Spending decisions are made through the processes established by the Maryland Health Benefit Exchange board. Board approval is required for competitively bid contracts over $200,000 and sole source contracts over $50,000. The Executive Director may approve contracts for less than these amounts, with notice to the Board of any emergency or other noncompetitive contract over $10,000, and any competitively bid contract over $25,000. With respect to information technology, Secretary Isabel FitzGerald has the lead role in recommending IT expenditures for board approval.

Summary information includes the following:

Year	Total	State Share
FY 2012 (actual expenses)	$13,747,808	$0
FY 2013 (actual expenses)	$37,257,056	$1,503,660
FY 2014 (working appropriation plus deficiency)	$138,026,507	$17,212,936
FY 2015 (projected)	$72,027,966	$28,513,882

Deficiency. The FY 2014 includes a $33 million deficiency request. This request, of which approximately $3 million is in state funds, is expected to cover an estimated $6 million in additional expenditures for the call center expansion and an estimated $14.4 million in additional spending for Optum/QSSI services. The deficiency request reflects the anticipated need for spending authority. It is possible that after further review of options (see next steps below), the Maryland Health Benefit Exchange will modify the use of deficiency funds further and/or request an additional deficiency.

Noridian contract. The table below illustrates the current status of payments to Noridian, the prime contractor for the exchange. Noridian has separate contracts for development, maintenance, and hosting. The latter two have five year terms, but may be terminated for convenience.

Total Contract Amount Over 5 Years	Invoiced	Paid

$193,430,579.21	$77,998,359.64	$64,989,423.67

Optum/QSSI Contract. In December 2013, the Maryland Health Benefit Exchange board approved a contract with Optum/QSSI on an emergency basis. The contract, which has a term of 18 months, provided for a not-to-exceed of $2 million for each of the first two months. Optum/QSSI is performing two critical roles at present:

- IT. Optum is assisting with project management, including implementing important software development and release processes. Optum is also providing strategic assessment and guidance on major IT decisions.

- Operations. Optum is providing significant person-power to manual workarounds, including manual enrollment options, through on site staff and off-site call centers. Optum has handled more than 32,000 calls.

The Maryland Health Benefit Exchange is currently making plans with Optum for continued assistance through at least June 2014. The total not-to-exceed amount through June has not been settled.

IT Contracts

At this point in time, the Maryland Health Benefit Exchange has contracts with four principal vendors for IT-related services. These are:

- Noridian Health Solutions, the prime contractor, which is responsible for the design, development and implementation of the system as well as maintenance, operations, data center and hosting services.

- Xerox, which is responsible for changes to the legacy Health and Human Services eligibility and case management system (CARES) to accommodate the introduction of the new system.

- Optum/QSSI, which provides advisory, assessment and general contractor IT support, and supports the operations of the exchange.

- BerryDunn, which provides third party independent verification and validation services of the project, and identifies and raises issues and risks to MHBE that may affect the project.

As of December 5, 2103, the responsibility for the management and oversight of IT was

assigned to the Secretary of the Department of Information Technology, Isabel FitzGerald.

Secretary FitzGerald established an integrated project management office to improve vendor oversight, establish clear project and vendor management processes, and decision-making. The Project Management Office consists of staff from the Maryland Health Benefit Exchange, BerryDunn and Optum. The oversight team and Secretary FitzGerald review all deliverables, prioritize work, oversee the testing and quality of the fixes, review and address deficiencies in the service level agreements, as well as work with Noridian to establish a schedule for current and future efforts. The team, including the Secretary, attends daily meetings and is embedded with the development teams to provide real-time oversight, and quality management.

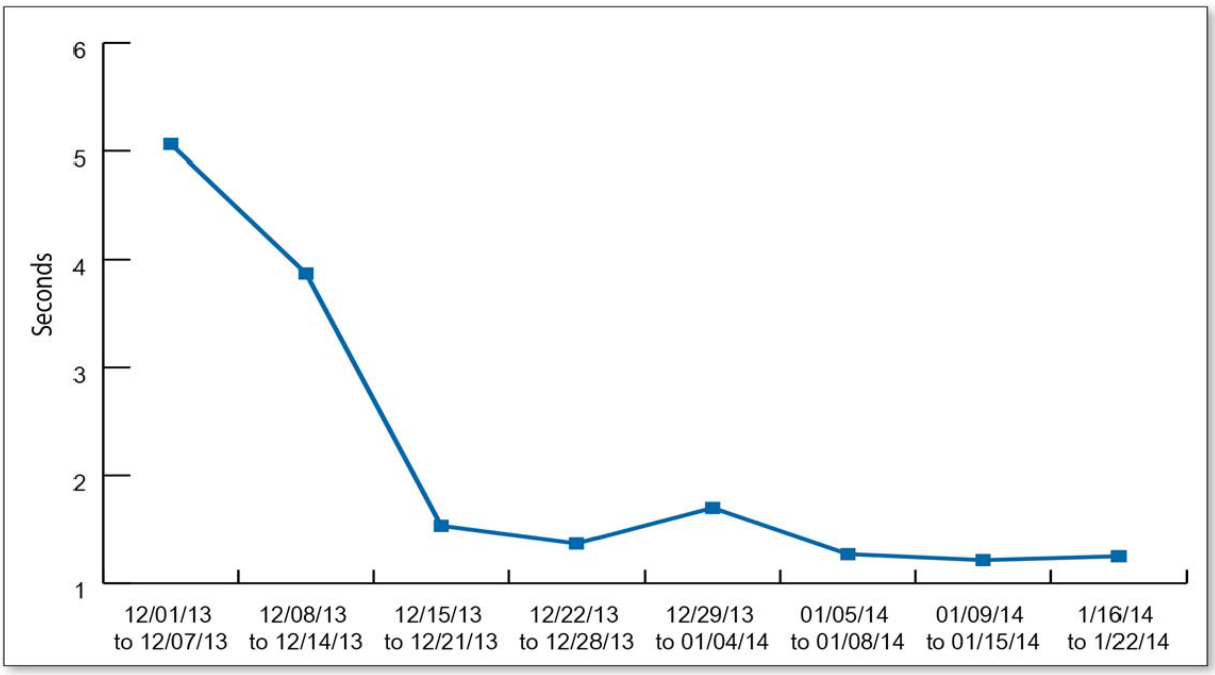
Secretary FitzGerald makes IT decision on a day-to-day basis. For decisions that would entail major scope changes or have financial or contractual implications, she makes recommendations. The decision would be made by a broader group, including staff from the Maryland Health Benefit Exchange and the Department of Health and Mental Hygiene. Major decisions and procurements are reviewed and approved by the Maryland Health Benefit Exchange board, which is chaired by Secretary Sharfstein.

Consumer Experience

In general, consumer experience has improved significantly since early December. However, the experience still varies widely, and is often related to when the user experience started. Early adopters often say the experience is poor, they are more likely to have experienced a great deal of frustration, and they are more likely to have required multiple contacts with the call center or may have had to re-apply. Recent users have fewer issues with the website, and issues tend to be on the back-end that require manual intervention, but may not necessarily be visible to the user.

The current user experience often is dependent upon the size and complexity of the household and the user's computer experience. The responsiveness of the login page has improved considerably.

Figure: Web portal response time, in seconds



The actual time to complete the enrollment process depends on the household size, income sources (if there are multiple), deductions and user preferences. As the size of the household, number of income sources, and potential deductions increase, so too does the amount of time it takes to complete the application and the likelihood of issues that will require consumer assistance. In addition, some users spend more time reviewing plan options and detailed benefit summaries for the plans they are eligible for, while others know exactly what plan they want.

In the best case scenario, the account creation process takes 5 minutes or less to complete. We have feedback from Connector Entities that they can successfully complete an application for an individual in as little as 15 minutes. Overall, if the individual has all of the necessary information and knows the plan they want, they can complete the entire process in as little as 20 minutes.

Currently, the most common issues experienced by consumers are around identity verification, account disablement, and application status and enrollment transmission.

Identity Verification. The HIX relies on the federal data services HUB for completing remote identity proofing (a requirement of the Affordable Care Act). This service captures demographic information from the user, pings several federal databases, and responds with a series of questions that only the identified user can answer (e.g. who holds your mortgage, what car did you buy in 2008, etc.). If an individual does not answer these questions correctly, we are unable to prove their identity and therefore they will need to either (a) try again or (b) walk into a local health department or social service agency or Connector Entity and pass through identity

proofing with manual verification.

Account Disablement. Users who use the wrong username / password combination three times will receive a message that their account has been locked out. There are CMS-required security measures around the amount of time an account should be locked out, which lead to individuals not being able to access their account for a defined amount of time, and may require the consumer to call the call center for the account to be enabled.

General Application Status and Eligibility Discrepancies. These issues are the most serious errors that consumers encounter and are generally related to defects in the Curam eligibility product that is supposed to determine eligibility and manage cases (see next section below). These include invisible and suspended applications, and, in some cases, the system is not creating final cases after application approval. Often these cases require significant manual involvement to successfully pass information to the carriers.

Consumers are Uncertain of Application Status. Many users are not certain about the status of their application once they complete it and enroll in a plan. The system will display an application status of "approved" or "disposed." These notations do not impact the enrollment, but they leave much to be desired from the end user's perspective as they are not certain the status of their enrollment, and do not currently receive any correspondence from the system. After consumers enroll in a plan, the system sends these enrollment transactions to the carriers and the Medicaid Management Information System to complete the enrollment process into qualified health plans and Medicaid respectively. Our system -- in large part, because of shortcomings in the Curam software -- is unable to provide real-time updates to consumers on whether their application has passed through successfully to a carrier or Medicaid.

Reliable Transmission of Enrollments. The transmission of enrollment data to carriers is based on an electronic transfer of enrollment data to the carriers, and a return of effectuated cases back from the carriers once the consumer has paid the premium. This is accomplished through an electronic exchange of data files. About 10 percent of enrollment files have errors in the transmission to carriers. These files are reviewed by both the MHBE and carrier IT teams and errors are corrected. The electronic transmission of data is working reasonably well. The major issue in the enrollment process is not related to the transmission of files. The major issue is that the Curam product sometimes produces incorrect eligibility determinations or the cases become stuck or suspended. In many cases, MHBE has to complete manual outreach to consumers and manually complete an enrollment file for transmission to carriers or manually correct errors caused by the Curam product so the file can be transmitted elongating the time.

The cause for the problems individuals have faced range from sub-optimized infrastructure configuration, software defects and less than intuitive design features, to major defects in the commercial-off-the-shelf product that was deployed.

Manual Workarounds

Despite the serious IT difficulties, there has been a major effort to support enrollment through manual processes. These include:

- Manual review of eligibility determinations;
- Manual plan selection, guided by a certified navigator or call center employee;
- Manual generation of 834s for carriers;
- Manual correction of 834s; and
- Manual entering of data into the Medicaid Management Information System.

The effort has been tremendous, involving multiple long days, nights, and weekends. For example, operationalizing the "retro option" was entirely done through manual processes. More than 100 employees and contractors have been involved in these activities.

Our goal is to maximize enrollment before the close of open enrollment on March 31, 2014.

The IBM-Curam Software

The Joint Committee has asked us to comment on the IBM-Curam software, including why it was chosen for use, and the problems experienced in Maryland and Minnesota.

Curam software is at the heart of the IT system adopted by Maryland. It is the software that determines eligibility and is supposed to manage the records of families eligible both for qualified health plans and Medicaid. Problems with this Curam software are a significant reason both for the difficult launch, and for the challenges we're currently facing with the Maryland Health Connection.

Why Maryland Chose Curam. We have provided as Appendix 2 several pages from the Noridian proposal that related to the Curam software. Curam is considered one of the leading social service eligibility programs in the world. During the period of the bid, Curam was acquired by IBM. The product was marketed in the bid process as an "out of the box" solution to the Affordable Care Act's challenge of determining eligibility that would "allow Maryland to safely and confidently address the challenges of health care reform, meet aggressive timelines, and maximize funding opportunities."

The Curam platform was also thought to be easily expanded to include other types of social service eligibility programs. We have provided as Appendix 3 a July 2013 white paper from IBM/Curam further explaining how the product was marketed. Of note, by this time, IBM/Curam was advertising that "Maryland's exchange, powered by IBM/Curam, is the first state-based exchange to submit information to, and receive information from, the Federal Data Services Hub."

Problems in Minnesota. In December 2013, Minnesota Governor Mark Dayton wrote the CEO of

IBM about “significant defects, which have seriously harmed Minnesota consumers” in the Curam software. The letter identifies 21 specific concerns, including problems with eligibility rules, difficulty for consumers and call center workers in understanding the status of applications, and a “black hole” for for thousands of applications. This letter is attached as Appendix 4.

Problems in Maryland. We have experienced a similar set of serious problems with the Curam software. We have communicated our concern both to senior executives at IBM and Noridian.

These problems have included:

1. *Immaturity of out-of-the-box product.* Curam was much less mature out of the box than represented to the State during the procurement process. Indeed, the product has required significant customization, causing delays and errors.

2. *Missing functionality.* The go-live date for MD HIX was October 1, 2013. The Curam product was not complete in September 2013. The core product development team had not built out important functionality, including linking cases between the internal and external portals, changes for life events, and appeals. As a result the go-live version of the MD HIX was not fully functional. To date, the Curam product is still not fully functional or completely developed.

3. *Defects.* The number of defects associated with the core Curam product continue to grow; there are currently more than 200 defects, many of which must be fixed for the system to work as intended.

4. *Stuck applications.* Applications have been “stuck” in Curam in various phases of processing – and we face significant challenges to “unstick” them. This appears to be due to the poor design and configuration of the evidence broker within Curam, which governs the way that data is delivered from the user interface to create cases within Curam. The Curam team has been unable to determine and fix the core issues, and efforts to run batches to fix and unstick the applications have been met with varying degrees of success. In some cases, these batch processes caused major performance issues with the system that affected internal and external users.

5. *Applications incorrectly pended.* Consumers have their applications incorrectly put in pending status, and the software will not permit caseworkers and call center representatives to resolve the pending issue.

6. *Two rules sets.* The Curam software has employed two separate and distinct rules sets– one for internal caseworker processes and one for external portal users. At times, it appears the rules engines are out of sync, which can result in the consumer receiving one result while the system records another. This is creating substantial manual re-work to address. Curam has been unable to explain the discrepancy or explain its impact on

consumers.

7. *No Product Delivery Code*. Curam is not consistently assigning the product determination or product delivery code. This applies to Insurance Assistance (APTC) or Medicaid. The consumer must have one or the other to determine which processing path should be followed. Without the code, the consumer cannot proceed.

8. *Lost Applications.* Applications have been lost in the system and cannot be located. Some applications have missing data that has not been recovered. In some instances, the lost applications have required the consumer to reenter the information. We have identified at least 18 different and unrelated scenarios that contribute to lost applications.

9. *Lack of mandatory data fields to drive workflow and case processing decisions.* Curam went live on October 1, 2013 without key fields being defined as mandatory. These fields were not required, and therefore the business rules of processing applications and tracking the application through its various phases failed. This resulted in lost and stuck applications, lost data, and costly rework and development activities.

10. *Database Structure.* We have no direct access to and very limited understanding of the Curam database and tables. There is no data model that the state can review, examine, and understand. We cannot get basic case information or status out of the system. Nor has Curam provided any staff to remedy this departure from industry standard by helping us to navigate the database and therefore find our data for critical reporting. This results in thousands of hours and dozens of people working intensively manual processes to produce reports. We have evidence that the tables within Curam are not related, meaning if data is manually changed on a case to correct a data error or change a decision based on an appeal – when a data element is changed in one place, it does not populate through the database. The tables are not related by keys or other identifiers to link the customers' case data together properly. The tables are not indexed or optimized resulting in poor system performance. The defects in database structure represent marked departure from acceptable industry database architecture standards.

The consequences of these problems include consumer frustration, as consumers are understandably upset that their applications have been lost. In addition, because of these problems, the call center cannot resolve issues for customers because the data is either not displayed properly or the applications are "stuck" resulting in multiple calls, delays and frustrated consumers. The State has spent thousands of person hours to address these issues and create manual processes to help Marylanders get enrolled.

Not only are our consumers frustrated, but our carriers are as well. Files are transmitted with an error rate of about 10%, requiring re-submission and rework. Our carriers have spent thousands of hours testing and working with us to correct issues resulting from the Curam product.

Most recently, we discovered that a Curam coding error was responsible for approximately 9,000 Marylanders receiving elevated tax credit amounts from January 8 to January 31. The error has

been corrected moving forward. We are now working with Noridian and Curam to understand the problem in greater detail and identify a solution that, to the extent possible, protects consumers from additional steps and cost. We will need to implement this solution in concert with the carriers. This is the latest in a number of frustrating incidents that have been caused by defects in the Curam software.

Despite all of these issues, it is important to reiterate that thousands of consumers are able to enroll in coverage, as a result of improvements to the site, consumer assistance, and significant manual workarounds. As we said at the outset, we strongly encourage Marylanders who need coverage to visit Maryland Health Connection dot gov.

Improving the Current System

Led by Secretary FitzGerald, the IT team is focused on identifying and fixing those issues that affect consumers' ability to enroll. The team meets daily and prioritizes incidents and issues, and works closely with the operations team to manage emerging issues and provide a clear line of communication. The team has been working around the clock to address the critical issues that were preventing individuals from enrolling in health coverage.

There have been 7 substantive code deployments that have addressed over 560 system defects, along with more than 120 "hot-fixes" or patches to the production code.

Secretary FitzGerald has provided clear guideposts for system improvement to the IT vendors. Because many outstanding defects are under active discussion, we will not be able to comment further on actions taken under the contract to resolve them, other than to state that the state reserves all rights under the contract. All contractual tools remain on the table.

Next Steps: Evaluating Alternatives

In early January, we evaluated the possibility of partnering with the federally facilitated marketplace for back-end services during open enrollment. We concluded that such a move did not make sense, in large part because the risk of a transition during open enrollment was high. We would have needed to build a new Medicaid database in short order, and significant work would have been required of carriers, who advised against it. In short, we concluded that continuing with our system through the end of the first open enrollment period was the only way to maximize enrollment by March 31.

We are seriously evaluating alternatives to our present IT structure after open enrollment. Working with Optum, we are actively evaluating several possibilities including:

- Adopting technology developed by another state;

- Joining a consortium of other states;
- Partnering with the federally facilitated marketplace for back end services; and
- Making major fixes to overhaul our existing system.

This will be a critical decision, and it requires due diligence and fair consideration of all of our options. Among the various issues for consideration is the re-usability of certain components that we purchased through Noridian. At the same time, we recognize that the earlier we can make the decision, the more time we will have to prepare for next fall's open enrollment. There is no specific deadline for a decision, and we will keep the Joint Committee updated.

We also recognize that these decisions may have significant implications for our current IT contracts and our funding requests to CMS. As these issues are under active review and consideration, we will not be able to comment on them at this time.

Conclusion

We appreciate the interest of the General Assembly in the challenges and progress of the Maryland Health Benefit Exchange. While it has been difficult launch, more than 150,000 Marylanders will receive health care coverage this year, many for the first time.

Also, while we have faced a number of technological problems as a result of problems with Curam and shortcomings with vendor performance, we have worked actively to make quality affordable health care as accessible as possible, to as many people as possible. We have increased the number of navigators, call center employees, and other facilitators; we have adopted manual workarounds; we worked with carriers to take the relatively unprecedented step of offering retroactive coverage; and we worked with members of this General Assembly to enact the MHIP Bridge.

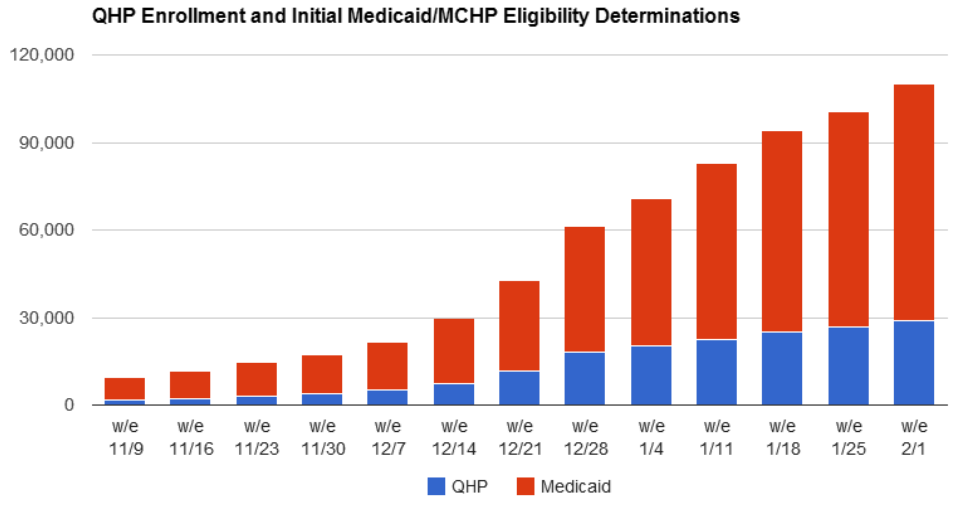
The challenges associated with the IT shortcomings have been great, but we are very proud of the work that the dedicated staff at DHMH, DoIT, the Exchange, and others have done to help as many Marylanders as possible access quality, affordable health care.

The frustrations we all share underscore the importance of access to affordable, quality coverage. We are working to realize the full promise of the Affordable Care Act in Maryland, and we will continue to do everything we can to succeed.

Report from the Maryland Health Benefit Exchange about Maryland Health Connection, the state-based health insurance marketplace

BALTIMORE (February 7, 2014) -- From October 1 through February 1, 2014, there have been 932,764 unique visitors to the Maryland Health Connection website. 151,593 Marylanders have created identity-verified accounts. Through February 1, 29,059 Marylanders have chosen to enroll in private health plans through Maryland Health Connection.

95,824 Marylanders signed up through the Primary Adult Care (PAC) program were automatically converted to Medicaid coverage effective on January 1, 2014, and now have full Medicaid coverage. As of February 4, an additional 44,592 individuals were newly enrolled in Medicaid effective January 1. In total, more than 80,000 Marylanders received an initial determination of eligibility for a Medicaid program through Maryland Health Connection.[1]



Information for Users of Maryland Health Connection

Open enrollment continues until March 31, 2014, so Marylanders will continue to be able to apply for, shop and enroll in coverage. Many of the technical glitches most frustrating to consumers

[1]As noted in previous reports, some of these individuals may have pending verifications before coverage is effective, and others may turn out to already have Medicaid coverage.

have been fixed, and we continue to work to address others that continue to cause difficulties for some Maryland consumers.

As more people learn about their health coverage options and the consumer experience on the website improves, enrollment through Maryland Health Connection into more than 60 medical and dental plans will increase. We anticipate that as many as three-fourths of individuals and families enrolling in private health coverage through Maryland Health Connection will qualify for tax credits and other assistance to reduce their costs.

Options when having trouble:

- *Visit the Consumer Information Update page for important notices before beginning*. These notices include advice on how to navigate some of the issues on the website as we work to address them.
- *Try again at a later time*. At times of peak usage, heavy volume can still cause errors and delays.
- *Call the Consumer Support Center toll-free at 1-855-642-8572 to discuss the issue or start an application by phone*. In response to high call volumes, additional staff are being trained to provide additional customer support. Hours of operation are Monday through Friday, 8 a.m. - 8 p.m., Saturday 8 a.m. - 6 p.m., and Sunday 8 a.m. - 2 p.m.
- *Talk to a consumer assistance worker or authorized insurance agent for assistance*. The link to contact information for connector entities in each of the State's 6 regions can be found on the Prepare for Enrollment page which is accessible from the landing page at the front of the website, or under the Individuals and Families tab under the heading of "Consumer Assistance." In-person assistance is available statewide through six Connector organizations and 50 supporting grassroots organizations that employ 158 navigators and 171 assisters.

Feedback:

- If consumers using the site run into any issues and want to provide feedback, they can do so via the link found on the Consumer Information Update page. Information from users is sent to Maryland Health Connection's technical team working to improve the user experience on the site.

Website availability:

- As the technical team continues to improve the experience of using the website, it may from time to time be temporarily unavailable. In addition, in order to perform routine maintenance, certain functions may be unavailable from 11 p.m. to 5 a.m. daily.

Insurance Producers:

- More than 2,000 insurance agents in Maryland have completed training to sell qualified health plans through Maryland Health Connection. A weekly communication to all authorized insurance brokers provides details about system updates and news to increase efficiency and address issues.

Spanish language:

- A Spanish language website will launch in two phases to meet the needs of Maryland's Latino community. The first phase of the launch, which went live in November, includes the information resources section of MarylandHealthConnection.gov where information, updates, outreach and resources are available. The second phase of the Spanish language website expansion includes the application portal. This functionality will launch during the first quarter of 2014 and includes account creation, application, shopping and enrollment.

Accessibility for persons with disabilities:

- Consumer information materials are now available in Braille and large print. The large print materials are available for download on the Maryland Health Connection Outreach and Education page. In addition, individuals can request to have Braille and large print materials mailed directly to them by calling the consumer support center at 1-855-642-8572. Individuals can also access the Braille and large print materials locally at the National Federation of the Blind, Maryland State Library for the Blind and Physically Handicapped, and the IMAGE Center for People with Disabilities. All of these organizations serve people across the state of Maryland. Consumers seeking services for the deaf or hard of hearing may call the Consumer Support Center toll-free at 1-855-642-8573.

Outreach:

- Outreach continues throughout the state seven days per week to educate consumers about their health coverage options. Grassroots outreach events are scheduled and available on MarylandHealthConnection.gov under the Calendar of Events for consumers to visit and speak directly with navigators and assisters in their local communities. In addition, enrollment fairs will be held throughout Maryland in the final two months of open enrollment. Dates and locations will be available soon at MarylandHealthConnection.gov.

Security of information on website:

- Maryland Health Connection, supported by experts in IT security at government agencies and through our IT team, has taken many steps to assure the security of the data entered on the website.

Accessing information about health plan benefits, rates, and providers before creating an account:

- We have posted a webpage, Prepare for Enrollment, which provides information on plans, shows sample rates for a range of scenarios, and provides instructions on the documents needed for the application for financial assistance. In addition, a Provider Search Tool, which is accessible through a link on the “Prepare for Enrollment” page, allows consumers to search for a doctor and find out the plans in which their doctor participates. A link to this tool is also made available to consumers during the actual plan selection process.

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Cúram for Healthcare Reform

The Cúram approach enables organizations to progress their transformation and compliance strategies with an eligibility, enrollment, and benefits delivery solution already employed by over 80 health and human services institutions globally. Because Cúram for Health Care Reform leverages this existing, proven functionality, and adds new, ACA-specific functionality, it will allow Maryland to safely and confidently address the challenges of health care reform, meet aggressive timelines, and maximize funding opportunities. The Cúram approach provides a clear roadmap for addressing the ACA's specific mandates and recommendations while supporting overall modernization efforts.

Cúram for Heath Care Reform provides the following benefits:

Focuses on the heart of ACA requirements of eligibility and enrollment. Streamlining eligibility and enrollment provides the greatest opportunity for improving the client experience by making it seamless, real-time, and paperless. Cúram for Health Care Reform provides pre-built rules, processes, and interfaces to support the integration between eligibility and plan enrollment within the Exchange.

Provides out-of-the-box capability to capture required data and accurately determine eligibility for "split families" – a family may be eligible for Federal subsidies with children eligible for CHIP or a family may include an aged or disabled member whose eligibility is determined in a more traditional way. The Cúram solution provides ongoing eligibility and enrollment to support the "churn" as individual and family circumstances change over time. The solution is designed to interface with the Federal data services hub to verify client data, and also includes the rules and processes to support traditional verification.

Supports a "No Wrong Door" approach to eligibility and enrollment. Cúram for Health Care Reform provides a streamlined, seamless, and consumer-centered user experience via a "unified front end" that spans users, programs, and channels across all required eligibility and enrollment processes in the Exchange.

Enables key business processes for enrollment and eligibility to be configurable including initial inquiry, screening, application submission, intake and verification, eligibility determination, renewals, and changes in circumstances. Multiple, program-specific business process models can be supported, including the ACA's streamlined business model and the "traditional" enrollment and eligibility models like specialized Medicaid programs and human service programs such as SNAP and TANF.

Provides role-based access for stakeholders, including consumers, agency workers, community partners, and providers through a channel-agnostic solution, which also supports the full range of interaction models for enrollment – full service, assisted service, and self-service. Includes comprehensive rule sets that drive eligibility and entitlement for human services, derived from analysis of over 100,000 rules artifacts spanning nearly 40 states and 25 programs. Our solution brings together the data, rules, processes, and users to provide a pre-built, content-rich, integrated rules architecture.

Supports the full range of Exchange functionality beyond eligibility and enrollment, including case management, appeals management, financial administration (including provider payment and premium collection), broker/navigator management, consumer account management, and consumer outreach and communications.

- Provides a solution SOA that meets all Federal and industry standards, including MITA and the CMS Seven Standards and Conditions.
- Integrates with existing state systems, and includes a number of pre-built adaptors and connectors to integrate with the various components and providers within a Health Insurance Exchange.

Cúram Software appreciates the complexity of program eligibility rules and has analyzed, compiled and built these rules into its product. For its health care reform application, Cúram Software analyzed more than 100,000 rules artifacts spanning nearly 40 states and 25 programs. The highly configurable product also allows for creation of workflows without the need for coding.

MDHIX 404

- Provides interoperability with Health Benefit Plan, Provider Display, Fund Aggregation and Payment vendors, and other enterprise systems such as call center solutions and electronic content management systems.
- Offers a range of deployment options that best suits business and technical strategies, including providing the platform for enterprise modernization that can support and streamline eligibility, enrollment and case management for the entire spectrum of Maryland's health and human services programs.

Cúram Software understands the challenges presented by the ACA in a way that few other vendor organizations can because the company is solely focused on developing the Cúram product suite which brings integrated health and human service solutions to social enterprise marketplace. Cúram Software employs a wide range of industry subject matter experts and former legislative analysts and federal employees who continuously monitor the industry and analyze the impact of changes. When new legislation is introduced, such as the Affordable Care Act, the company not only provides an initial solution module supporting eligibility and enrollment, but delivers regular product updates, ensuring that the Cúram solution maps to required State and Federal standards, policies and legislation at any given time.

IBM Cúram Solution for Healthcare Reform

IBM Cúram Solution for Healthcare Reform empowers agencies to meet the ACA 2014 deadline while investing in a platform for the future that is capable of meeting the long-term goals of the organization.

IBM® Cúram Solution for Healthcare Reform provides the core, foundational elements of a health insurance exchange. It incorporates packaged subject-matter expertise, such as built-in evidence, rules and workflow, that are specific to the healthcare reform initiative.

This integrated eligibility platform can support all health and human services programs, enabling organizations to address current reform and to optimize funding, while building a foundation for the future. In addition, for states that have chosen to use the Federally Facilitated Marketplace (FFM), the IBM Cúram solution provides an option to transition to a state-based exchange.

Lower risk, rapid path to implementation

IBM provides a reliable and flexible solution that is capable of adapting to a variety of state deployment options. IBM Cúram Solution for Healthcare Reform is built on an architecture that can scale to meet the spikes in demand created by open enrollment. This solution includes prebuilt business and technical components that support incremental implementations and enterprise modernization. Components can be exposed as web services, making the IBM Cúram solution one of the most content-specific, modular platforms offered.

The IBM Cúram solution provides robust process support for both high-volume, web-based transactions and high-complexity, full service casework, and has been proven in over 70 successful implementations worldwide. The solution foundation is based on one of the only social services-specific data models available in the industry that is:

- Client-centric and multiprogram to meet enterprise-wide needs
- Developed with over 20 years of investment
- Tried and tested in the US and around the world

IBM follows a product strategy and development roadmap that is tailored to meet Affordable Care Act (ACA) mandates and evolving federal requirements and guidance. With the IBM Cúram solution, states are supported by one of the world's largest, most experienced social services development organizations.

IBM Curam Solution for Healthcare Reform is a content-rich, commercial off-the-shelf (COTS) solution that includes:

- Prebuilt rules, data, and processes that are needed to meet ACA mandates and the critical success factors of the Centers for Medicare & Medicaid Services (CMS)
- A packaged, content-focused, integrated rules architecture to support enterprise-wide eligibility and entitlement
- Packaged adaptors that are designed to support communication between IBM Cúram applications and external systems, including the Federal Data Services Hub, solution partners, and other trusted sources

IBM is committed to providing ongoing product support for major legislative changes. IBM Cúram solutions feature automatic updates for legislative changes to help ensure continued federal compliance, in addition to technology refresh that protects from obsolescence and provides access to new technology. IBM will continually work with clients to help ensure product integrity and access to support and innovation.

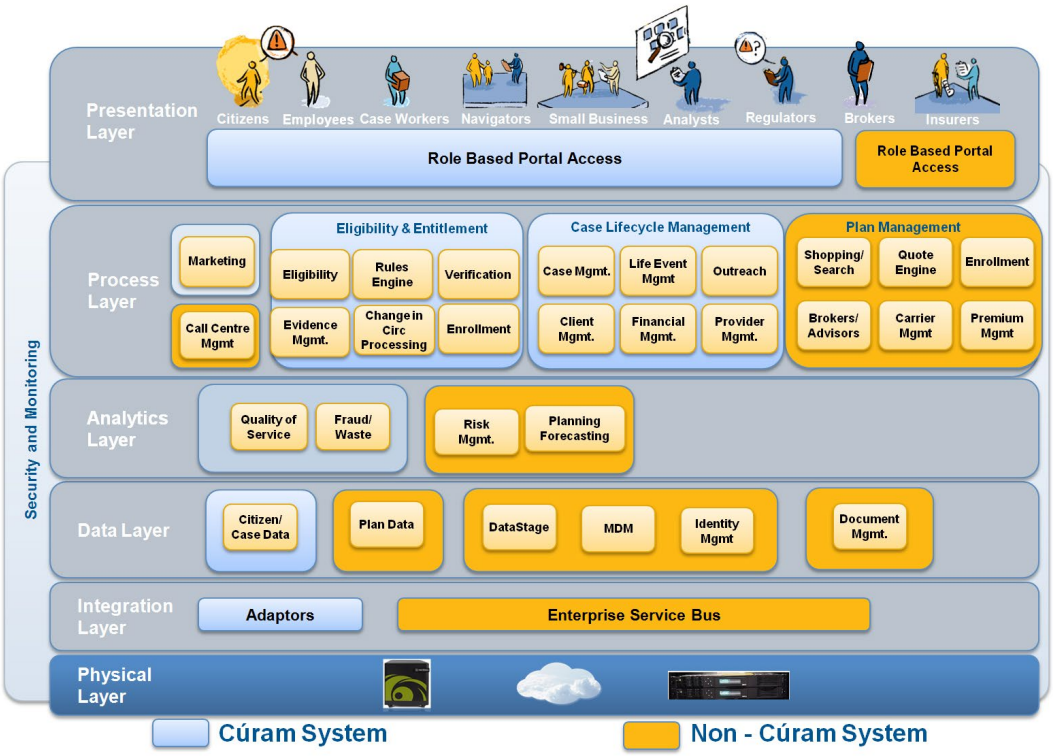

Figure 1: IBM provides a reliable COTS solution with prebuilt, social services-specific content that helps states meet an aggressive federal deadline, reduce risk, and support the entire enterprise with a purpose built platform.

Federal standards compliancy

IBM understands the importance of federal standards such as Medicaid Information Technology Architecture (MITA), Section 508 and the CMS Seven Conditions and Standards for enhanced funding. IBM Cúram Solution for Healthcare Reform meets federal conditions and standards with:

- A modular, interoperable application with componentized business modules that are developed on a flexible, open architecture
- An externalized, social services-specific rules engine and prepackaged core processes that are needed to support communication between data and rules to initiate eligibility in a scalable way
- A service-oriented architecture (SOA)-based offering with exposed application programming interfaces (API) that can plug into the broader enterprise architecture, helping enable full business interoperability

The IBM Cúram solution is compliant with MITA and industry standards to help minimize customization demands and optimize business outcomes:

- Aligns with MITA standards
- Adheres to Health Insurance Portability and Accountability Act (HIPAA), National Information Exchange Model (NIEM), National Institute of Standards and Technology (NIST), and other applicable federal and industry standards
- Complies with Section 508 of the Americans with Disabilities Act

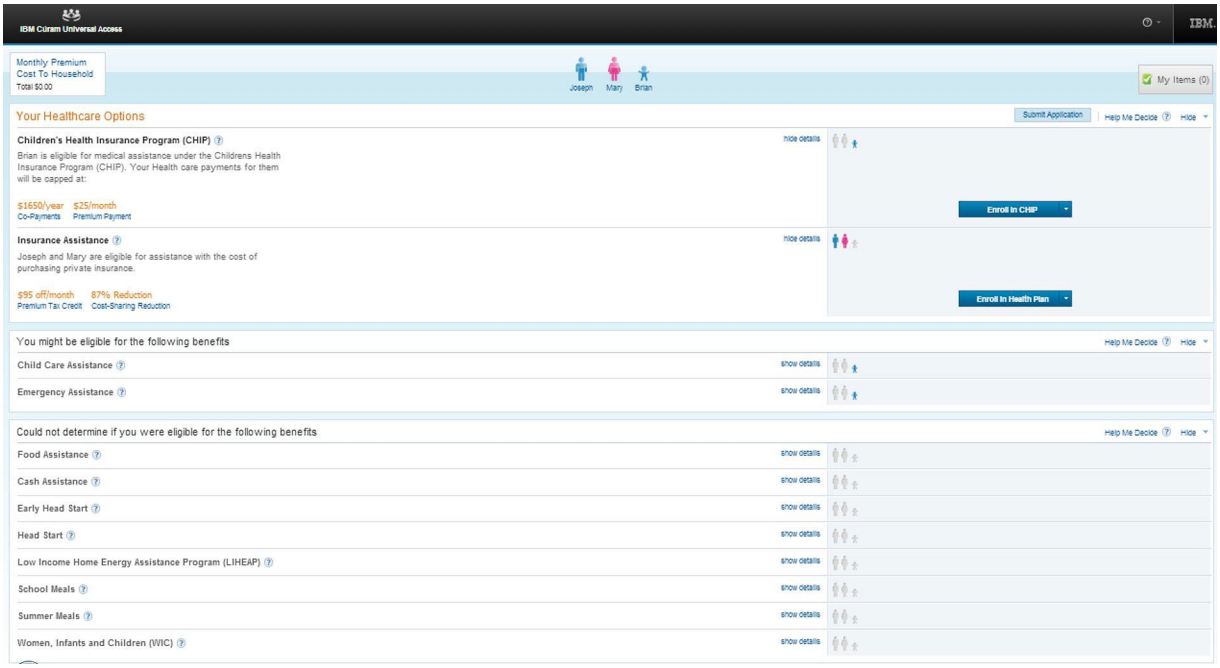

Figure 2: IBM Cúram Solution for Healthcare Reform provides a modular, enterprise eligibility and entitlement platform that fulfills the spirit of the ACA and complies with the CMS Seven Conditions and Standards, MITA, and other applicable federal and industry standards. The IBM Cúram solution also helps facilitate compliance, enabling states to qualify for enhanced funding.

In addition, IBM Cúram Cúram Solution for Healthcare Reform helps states meet the CMS critical success factors in the following ways:

- The IBM Cúram solution includes a complete streamlined application, providing states with the ability to accept application data.
- The solution is delivered with Modified Adjusted Gross Income (MAGI) rules for both initial eligibility and ongoing case management.
- MAGI conversion is accommodated through configurable rules logic that is included in the solution.
- Configuration capabilities allow state thresholds and flexibilities to be applied to the solution.
- The IBM Cúram solution acts as the required single endpoint for the FFM, providing the four account transfer interfaces that states need.
- The IBM Cúram solution provides the required connections to the Federal Data Services Hub. Maryland's exchange, powered by IBM Cúram, is the nation's first state-based exchange to submit information to, and receive information from, the Federal Data Services Hub.
- The IBM Cúram solution's connections to the Federal Data Services Hub facilitate the required Minimum Essential Coverage (MEC) check, providing client enrollment status for Medicaid and Children's Health Insurance Program (CHIP).

IBM provides an extensible offering that is designed for reuse and sharing between states through packaged business processes that are designed, developed, and tested per ACA requirements. The IBM Cúram solution promotes sharing and reuse within a state by using a common solution that supports enterprise processes. By design, IBM Cúram Solution for Healthcare Reform can support and help enable effective and efficient business processes that are required under the ACA, including a universal access approach to eligibility and enrollment that can be used across the organization. IBM understands the importance of federal compliance and incorporates analysis of emerging standards with every release. As a result, IBM Cúram Solution for Healthcare Reform not only aligns with the standards of today, it will be continually enhanced as standards evolve.

A platform for the future to help optimize funding

IBM Cúram Solution for Healthcare Reform helps optimize enhanced federal funding by providing built-in, end-to-end support for all health-related programs. The IBM Cúram extensible eligibility and entitlement platform offers:

- An opportunity for states to take advantage of a lower cost allocation burden
- Support for the essence of the ACA by avoiding yet another eligibility silo
- Easier compliance with federal standards, enabling states to qualify for enhanced funding

The IBM Cúram solution can increase the return on investment by providing an integrated eligibility and entitlement platform that:

- Can be used to support all health and human services programs over time
- Helps eliminate data redundancy and reconciliation with a client-centric, multiprogram data model
- Uses continued and significant investment in research and development provided in a COTS offering
- Provides FFM states with a path to operate their own state-based exchange

Cúram Solution for Healthcare Reform enables agencies to manage project scope and helps ensure long-term success. Predefined, stand-alone business components support incremental implementation and provide optimum choice and flexibility in deployment strategy. Distinct, social services-specific components and processes can be implemented to support ACA requirements and enterprise-wide program objectives. End-to-end solutions can be implemented to support a health and human services transformation.

The IBM Cúram solution provides a federally-compliant enterprise eligibility and entitlement platform that can be implemented now as part of the health insurance exchange by using enhanced funding, while providing a foundation that other human service programs can use incrementally.

Short-term action, long-term benefits

Healthcare Reform is one critical, immediate piece of the social services puzzle that can lead to improved outcomes for citizens. Healthcare Reform provides agencies with a rare opportunity to invest in an IT platform strategy that addresses the immediate requirements of the ACA while supporting future program and service delivery innovation across the health and human services spectrum.

IBM is distinctly suited to assist agencies in meeting ACA mandates and to help maximize their investment in a platform for the future that provides a:

- Tried and tested COTS solution with prebuilt, social services-specific content
- Modular enterprise eligibility and entitlement platform that fulfills the spirit of the ACA, facilitates compliance with federal and industry standards, and enables states to qualify for enhanced funding
- Solution that meets immediate mandates while providing a foundation that other human service programs can use incrementally to provide holistic service and improve outcomes for citizens

For more information

To learn more about Cúram software, please contact your IBM representative, or visit: **ibm.com**/software/city-operations/curam-software

To learn more about all of the IBM Smarter Cities solutions, visit: **ibm.com**/smartercities

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STATE OF MINNESOTA
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December 13, 2013

Ms. Virginia M. Rometty
Chairman, President, and CEO
IBM Corporation
1 New Orchard Road
Armonk, New York 10504

Dear Ms. Rometty:

I am writing in regard to your Curam HCR product, which serves as the eligibility and case worker product for Minnesota's state-based marketplace, MNsure. Your product has not delivered promised functionality and has seriously hindered Minnesotans' abilities to purchase health insurance or apply for public health care programs through MNsure. I request that you immediately deploy whatever people or resources are needed to correct the defects in your product that are preventing Minnesotans from obtaining health insurance through MNsure.

During the 2011 procurement for MNsure's information technology services, Curam represented that the HCR product was 90% complete and ready out-of-the-box. Minnesota was told that we would simply need to configure the product. We now know that the product is still not 90% complete in December of 2013, and that your product has significant defects, which have seriously harmed Minnesota consumers.

These defects were noticed immediately after October 1, 2013, when we began using the Curam HCR product. Almost immediately, clients began to submit multiple applications for health insurance, because the product did not limit individuals to one application and your product staff did not know this could occur. Your product provides the functionality to withdraw an application, although withdrawing an application does not pass the information to products responsible for enrolling people in health plans or processing premiums. Consequently, Minnesotans have had very confusing and unsatisfactory consumer experiences in trying to submit applications and purchase coverage. These errors have forced MNsure staff to spend thousands of hours trying to clean data and make consumers whole.

Similarly, the Curam product did not properly perform eligibility determinations or verify individuals' application information, as required under federal law. The fact that this functionality was not working was known to Curam staff, but was not communicated to MNsure. These defects have caused terrible consumer experiences. Families had their applications inappropriately put into pending status, and MNsure had no ability to assist the consumers. Families also had incorrect eligibility determinations, and MNsure had no tools to correct the situations. MNsure staff spent four weeks working with your team to create and use a mechanism to resolve the verification and eligibility determination problems in large batches. These batch processes never worked. MNsure staff needed to spend thousands more hours manually addressing the issue on a one-by-one basis.

All of these defects and the manual work they necessitated have delayed MNsure's ability to: 1) send families eligibility notices; 2) send health plans enrollment data; and 3) send clients invoices. Even now as Minnesota sends this information, the data being sent is not always accurate. Oftentimes, the information displayed to consumers through the Curam Citizen Portal does not match the data on the Curam Caseworker Portal, because those two portions of your product do not work together.

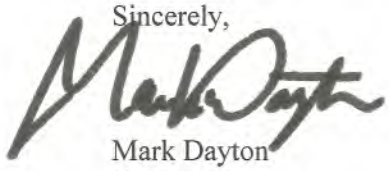
Your product has made it impossible to provide Minnesotans with any reasonable customer service. Our Call Center wait times have averaged over 50 minutes. We did not anticipate this volume, as these product issues were not made known to MNsure. The cost to address them and make sure consumers will have coverage on January 1, 2014, is excessive and unacceptable.

One additional defect (out of many others) concerns me greatly. MNsure has learned that some consumers get stuck in a queue and their applications are not able to be processed. Curam product staff do not know why this is occurring, have been unable to identify which applications are in this queue, and have not been able to remove these Minnesotans from the queue to process their applications and get them coverage. <u>This must be rectified immediately</u>.

Minnesota created MNsure to ensure that Minnesotans had easy access to affordable, high-quality health insurance. Unfortunately, we have not been able to fully deliver on that goal, largely because your product does not have the necessary functionality, which you committed to delivering. I personally met with members of your staff several weeks ago to raise the importance of many of these issues. Since they have yet to be resolved, I am asking for your immediate assistance. I urge you to fulfill your commitment and help us deliver a reliable and satisfactory experience for Minnesotans. I request again that you deploy immediate resources to correct the defects in your product, which are preventing Minnesotans from obtaining health insurance through MNsure. A partial itemization of those defects is attached.

I will call your office today to request a telephone conversation with you to discuss these urgent matters. I ask you please to make time available for that call in the very immediate future.

Sincerely,



Mark Dayton
Governor

Attachment

IBM/Curam Issues

1. We were told when we selected IBM/Curam that 90% of the product was complete, however, we were not provided with any documentation from Curam regarding their product. This lack of documentation results in confusion by staff and it is hard for us to understand how it works on the backend or run queries of the databases without Curam assistance. Whenever we ask a question in regards to how the system will function we are told to go into the system and test it out. There is no documentation where we can look to see, for example, the structure of the various rules engines, how cases are created, what evidence exists, how information from the application is carried over into the application, or how information is shared and transferred between what we see (administrators, caseworkers, counties) and what the consumer sees, etc.

2. The various eligibility rule sets were either incorrect or out-of-sync, which causes incorrect eligibility determinations or different eligibility outcomes between what the client sees on his/her account and what is displayed internally to workers. We/DHS staff worked tirelessly to fix the eligibility and application issues and needed to have the federal government intervene to fix certain things. Curam changed their application and the feds approved it and we took nearly all of what the feds approved, but we learned after go live that errors occurred that we thought were fixed.

3. The batch to reassess eligibility has not worked after various attempts. As a result, internal staff had to manually manipulate the system to trigger a redetermination of eligibility on each case one-by-one. This process took over a month, many hours of staff time including efforts of the counties, and has caused more errors to fix manually.

4. There is no way for the client to see on his/her account the result of any reassessment of eligibility. In fact, the individual sees only the results associated with the first time he/she applied which may be different than what has subsequently been determined. This has caused consumer confusion and increased call volume to the call center.

5. There is no way for the call center staff or caseworkers to see the eligibility results that were presented to the client at the time the application was submitted. We only learned this after the reassessment when we learned that the results shown to the consumer did not change.

6. There is no way for an individual to report changes online. The out-of-the-box (OOTB) functionality was confusing and otherwise inadequate for us to implement. As a result, all changes have to be reported directly to a caseworker or call center worker and tracked manually.

7. There is no way for a client to enroll in a plan if an eligibility change results in a change of program—i.e., person goes from being ineligible for tax credits to eligible for tax credits. We must close their case and have them reapply to allow them to enroll in new coverage.

8. In order to close a case, a case worker must change a piece of evidence to make them ineligible for the exchange – we must change evidence to say they are not a Minnesota resident. This

change in evidence triggers a notice to be sent to the individual telling them they are denied for MNsure because they are not a Minnesota resident. This requires us to contact all applicants where we are closing a case to tell them to disregard this notice. This is the only way we can close a case – there is no manual override functionality.

9. At some point after going live electronic verifications were no longer working and this was known by Curam and they did not tell us till we found it ourselves through tracking logs. This is one of the reasons we had to rerun everyone through the system to improve customer service so consumers would not need to provide paper verifications. However, the rerun did not work and took over a month and resulted in more errors, consumer questions regarding why they were pending, many calls to the call center, delayed invoices and notices, and delayed sending of 834s to the carriers to effectuate enrollment for consumers.

10. If anyone on a case is being pending for a mandatory verification for Medicaid, the system pends eligibility for all programs. This is not following the regulations. For people eligible for MinnesotaCare or APTC, the regulations require us to not delay eligibility and instead base the eligibility determination on the attested information and give clients a 95 day reasonable opportunity to provide the verification. Just because someone else on the application may be eligible for Medicaid does not allow us to ignore that regulation. This is a big issue for Minnesota because our Medicaid standard is so high for children and pregnant women that we have a lot of mixed households.

11. Thousands of applications are delayed or never show up for the call center staff or caseworkers to see because they go to either a dead message queue or a process instance error (PIE) queue. Clients submit an application online, and potentially even enroll & pay for a plan but we have no record of them in the eligibility system. There are over 2600 of these in the PIE que and Curam cannot tell us how many are cases or just error messages. They also cannot tell us who they are and they cannot get them out of this black hole. We were not told of this nor did we see or know to test for it before we went live.

12. The system at go-live allowed an individual to submit multiple applications, both for assistance and without. As a result we had individuals with multiple applications in the system with duplicate MNsure IDs and who sometime enrolled in different plans multiple times. We have spent a lot of time manually cleaning up these cases, and are still working through fixing these cases. We did not see this in testing and Curam staff on the ground did not even know it could happen and did not know how it was happening.

13. The system at go-live allowed an individual to withdraw his/her application through his/her account but we were not aware of that and that functionality was not supported through the end-to-end process. As a result, clients would withdraw his/her application thinking they were closing out any enrollment or refunding any money paid for a plan; however, it was just withdrawing their application and leaving the enrollment and financial information intact. The

other vendors working on enrollment and financials did not know this could happen – again, no documentation and we had to trust the vendor staff on the ground.

14. Curam implemented determinations for Emergency Medicaid into production without the State knowing about it. Our requirements were not fully implemented (such as adding eligibility questions to the application) and it was never tested. We were unsure what information was present to the clients on the eligibility results page or what notice, if any, was sent to them.

15. The system does not allow an individual who currently has minimum essential coverage (MEC) *that is ending* to apply and be determined eligible for MinnesotaCare or APTC. As a result, it will guarantee an individual will have at least a one month gap in coverage. For example, if an individual has employer insurance that is ending in January, the individual will need to apply in February in order to be determined eligible for MinnesotaCare or APTC. Since that coverage does not begin until after payment is received, the soonest coverage could begin would be March. This must be fixed asap by January.

16. We have intermittent issues with seeing an individual's benchmark plan on the call center/case worker side of the system. As a result, we cannot see on the call center/case worker side the amount of any tax credit available to a client. Sometimes this has worked, but Curam has put in other fixes that have disabled this.

17. Eligibility notices only supported 8 ineligible reasons, so we had to manually develop and send notices for individuals who were determined ineligible for a different reason.

18. We cannot process paper applications – this appeared to work initially in testing but we have found that the application cannot be connected to an account. So, if someone applies with a paper application and is determined eligible to enroll in a QHP, there is no way for the individual to enroll in a plan.

19. Security roles were not adequately applied by Curam staff at go live. As a result, internal staff either could not see all of the information we were expecting them to see (such as evidence details) or they could not perform certain functions.

20. We have no way to upload paper verifications or view system-issued notices for consumers as they are not stored in the caseworker portal. For verifications we need to have case workers essentially say they have verified it but the system cannot store the evidence.

21. We discovered a security issue with Curam in mid December where their log out functionality was not working and they had a 30 minute timeout that was creating issues for navigators with repeat clients within 30 minutes. We told Curam to fix the log out functionality and change the timeout to 10 minutes. We were told this was done, but when we checked recently, the 30 minute timeout was not changed.